Dignity, care and support for older women from Black and Minority Ethnic (BME) backgrounds: Service providers' perceptions

A Report compiled as part of a larger Study: *'In their own words': Capturing the voices of older women from black and minority ethnic (BME) backgrounds in order to understand their perceptions of dignity, with a focus on care and support*

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Summary

The aim of this research was to explore service providers' perceptions of how dignity could be enhanced or diminished, with a focus on care and support offered to community dwelling older people from black and minority ethnic (BME) backgrounds. A survey design was used to explore the following key areas of professional practice: the care of older women from minority ethnic backgrounds, the perceptions of the views held by these service users in respect to their care and support, barriers or areas of challenge in providing culturally responsive care, and lastly, the facilitators and enhancers of intercultural care that was responsive to ethnic and cultural difference. Data were collected between March and June 2012 via a purposely developed questionnaire, with 124 responses received. A telephone discussion on examples of effective practices and responsive services was conducted with 14 respondents after the survey. The majority of the respondents were female from a white background. A large proportion of respondents (n=54, 43.9%) worked in the third sector, followed by the public sector and the private sector. The largest numbers of respondents were involved in providing support (48.4%), followed by those managing services (35.5%), supervising others (23.4%), and delivering hands on care (17.7%). Respondents from a minority ethnic background comprised 18.6% of the sample, and the majority of them worked in the third sector.

Key Results

- *Respect was mentioned most frequently with regards to dignity. Respect was strongly associated with dignity, and was communicated or manifested itself, through actions and behaviours.*

- *The majority of respondents perceived that older women from a BME background would think they were offered the opportunity and support to express their needs, but just under one quarter of the respondents (22%) thought they were seldom offered the opportunity, and 7.7% thought they were seldom offered support.*

- *Respondents perceived that older women from a BME background would think their physical needs were most often taken into account, whereas their cultural needs were least often taken into account.*

- *One quarter (25%) of the respondents perceived that older women from a BME background were seldom involved in decision-making about their own care, and 2.8% perceived that they were never involved.*

- *Close to one half of respondents (44.1%) perceived that older women from a BME background could seldom or never choose which language they wished to use to communicate, and 31.9% believed that this population group were seldom or never provided with information relevant to their ethnic or cultural background.*

- *The top five barriers which made it difficult to provide intercultural care with dignity were a lack of staff who can speak community language, a lack of interpretation services or limited access to interpreters, a lack of staff training, limited time and not recognising the culturally specific needs of older people.*

- *The top two barriers or challenges to providing responsive services were addressing the way local services were accessed, and not taking into account of older people's culturally specific needs when designing services.*

- *With regard to key elements which might help respondents provide better care or support to older women from a BME background, staff training and recognition of and information tailored to older people's needs were most frequently reported.*

- *Over 50% of respondents with a supervisory or managerial role reported managers as well as care plans, internal policy and best practice guidelines as sources of care information. Best practice guidelines were seen as a source of care information for over 50% of respondents who worked in the third sector.*

- *Over half of all respondents indicated they sourced external support and information from organisations that mainly work with older people. This was closely followed by organisations providing health and social care, and organisations mainly working with older people from a BME background, all of which were referred to by around half of all respondents. Equality organisations and cultural associations were referred to by around a third of the respondents.*

- *Other sources of information and support came from family members and friends of the person respondents provided care or support to (72.5%), the person they provided care or support for (67.5%) and by drawing on their own experiences (55%).*

- *Most respondents thought that older people from a BME background and their family members were often unaware of services especially mainstream services available for them. They also thought that a social support network was often not in place to facilitate access to relevant services on older people's behalf.*

- *Lack of funding was frequently seen as a key factor that had hindered the development and adaptation of support and care; this was even more of a pressing concern for those based in third sector organisations.*

- *Among some respondents it was stressed that staff members tended to be constrained from learning about and responding to culturally appropriate care which often required more time and effort to plan and put into practice.*

- *Respondents reported that there were often few referrals of users from a BME background via social services or self-referrals. They felt unsure how and where to approach them and acknowledged difficulties in informing older people of newly developed programmes or service.*

PART ONE

1. Introduction

The population of the UK is ageing fast. Over the period 1985-2010, the numbers of people aged 65 and over increased by 20% to 10.3 million, accounting for 17% of the total UK population in 2010 (Office for National Statistics 2012). In the same period, the number of people aged 85 and over more than doubled to 1.4 million, and by 2035 this number is projected to be almost 2.5 times larger than that in 2010, reaching 3.5 million and accounting for 5% of the total population. Similar to the UK population as a whole, the Black and minority ethnic (BME)[1] population is now ageing rapidly (Lievesley 2010). The increasing numbers, longevity, as well as the heterogeneity of the older population are some of the pressing challenges facing social service providers, commissioners and policy makers.

In this report, older people are adults aged 50 years and older, as defined in the *Wales National Strategy for Older People* (WAG 2008). The overall focus of this study is on older women from minority ethnic backgrounds. We explored issues of dignity and the provision of care and support to this population group from the perspectives of service providers. Research on ethnicity and ageing has highlighted that older people, regardless of their ethnic and cultural backgrounds, share common expectations about the quality of services and the importance of dignified care (Cattan & Giuntoli 2010). However, older people also have individual expectations, aspirations and desires based on their life

[1]The concept of race has been a pervasive force in the development of modern western society. Having no biological basis, what we know as 'race' can be defined at its most basic level, according to Winant (2000), as a concept that 'signifies and symbolises socio-political conflicts and interests in reference to different types of human bodies' (p.172). Accordingly, racialisation is the process by which people and groups of people are ranked on the basis of their presumed racial differences and the attendant meanings of such differences in particular contexts. The process has long been contested and problematised. In the UK, the terms 'minority ethnic' or 'ethnic minorities' are most often used to refer to all minority groups of the population not indigenous to the UK that hold cultural traditions and values derived, at least in part, from countries of their or their ancestors' origin. The term 'black' is often used not only to differentiate black minority groups from other minority ethnic groups, but rather to ensure that the continuing impact of the legacy of racism remains highlighted and is made problematic. The term 'Black and Minority Ethnic' (BME) people, populations and groups will be used in this report, with key minority ethnic groups taken as those included in the UK census classification system. It is axiomatic that BME populations are heterogeneous, with differences both within and between groups.

experiences, and cultural, religious and ethnic background (Bowes & Dar 2000). Moreover, it is axiomatic that how services are used and experienced by individuals from different ethnic groups is just as much a product of individuals' own beliefs, needs and expectations, as it is a product of the attitudes and perceptions of service providers (Koffman & Higginson 2001, Bowes & Wilkinson 2003, Moriarty & Butt 2004).

1.1 Dignity and care with dignity

The importance of the diversity of older population groups is of importance when exploring the concept of dignity, a multi-faceted concept that draws on an older person's sense of identity, their sense of autonomy and their human rights (Anderberg et al. 2007, Gallagher et al. 2008). Dignity is understood to be ascribed based on role, position or achievement, on moral integrity, on personal identity, or on the innate, inalienable value as a human being, with these dimensions shaped by the wider social and cultural contexts in which care-related social interaction takes place and in which dignity is enhanced or diminished (Saltus & Folkes, in press).

Although dignity is hard to define, people clearly know when it is missing from, or when it has been enhanced by, their encounters with other people. As such both researchers and policy makers have sought to develop defining attributes or key indicators of dignity in the context of care. This growing body of evidence underpins practice, with domains and indicators of dignity used in monitoring and assessing care and service delivery within a range of health and social care settings, such as recognition and acknowledgement of autonomy, personal identity, participation and control, choice, effective communication, personal care, privacy and independence (Faulkner 2006, Matiti & Cotrel-Gibbons 2006, Anderberg et al. 2007, Picker Institute 2008, Clark 2010).

Such work must, in turn, be set within the context of the UK policy shift towards promotion and maintenance of dignity, quality of life and well-being in old age (DH 2001, WG 2003, 2006). The significance of dignity and the need for a good quality of care are reflected in various health and social care professional codes of conduct (e.g. NMC 2008, General Social Care Council 2010). Launched by the Department of Health

in 2006, the Dignity in Care Campaign has shown the government's commitment to addressing the lack of dignity and respect in health and social care services through raising awareness of dignity in care and inspiring people to take action (http://www.dignityincare.org.uk/). In Wales, the Welsh Government has funded a Dignity in Care programme, an essential part of the National Service Framework for Older People, that aims to promote a care system where there is zero tolerance of abuse of and disrespect for older people (http://www.ssiacymru.org.uk/index.cfm?articleid=4048).

1.2 Social care and support

The term 'care' not only describes activities and tasks related to caring but also implies a set of ideas in relation to approaches to and outcomes of care (Fine & Glendinning 2005) Our understanding of social care and support is rooted in two key points. First, the fact that what constitutes 'care' and 'support' may be interpreted differently between and within different ethnic groups (PRIAE 2008). However, care and support preferences are not shaped exclusively by cultural traditions and ethnicity, but are mediated through a complex set of social, intercultural interpersonal and pragmatic factors and reflect dynamic and evolving decision-making taking account of personal preferences and values, individual agency, knowledge about and acceptability of services, family roles, relationships and social networks (Moriarty & Butt 2004, Gunaratnam 2006, Seymour et al. 2007). Second, the delivery of care and support is understood as operating within a specific context which includes the providers and recipients of care or support, the relationship between them, and the social domain and institutional setting within which care and support is planned, provided, managed and evaluated.

1.3 The views and perceptions of service providers

This study aims to contribute to the empirical research evidence on the views service providers hold with regards to their care practices and on the provision of care and support to an increasing diverse client group. Recent research carried out with older people from a minority ethnic background provides some important empirical context. With regards to dignity and respect in the delivery of care, in Bowes et al.'s (2011) study

on care for ethnic minorities in residential homes, both frontline and managerial staff identified aspects of care provision that are vital to ensuring care with dignity for older people. They highlighted the importance of practising respectful communication by using appropriate forms of address with residents, and speaking rather than shouting. Also, providing flexible care, and adopting an individualised care approach with respect for individual preference and personal choice, particularly in relation to personal care which was deemed to be a particularly sensitive and private issue. In relation to older ethnic minority residents specifically, dignity was linked to respect for cultural preferences and respect for elders.

Other studies highlight the fact that provision for linguistic needs, respect for cultural preferences or gender conventions in relation to personal care is acknowledged and understood to be important by service providers (e.g. Bowes & Dar 2000, Patel 2000, Badger et al. 2012). The challenges faced in delivering responsive care in health and residential settings has also been explored, including maintaining service provider values and standards, addressing interpersonal conflict in care home with increasingly diverse staff and clients, addressing racism, discrimination and stereotyping faced by older minority ethnic population groups, and seeking to address issues of access and awareness of sources of care available (Gerrish 2001, Patel 2000, Gunarantnam 2001, Badger et al. 2009, Bowes et al. 2011).

Moreover, there is evidence of care providers demonstrating cultural competency in their approach to care for diverse population groups by firstly recognising and respecting the individual preferences that cultural diversity produces, and secondly by attempting to implement care delivery in accordance with these various needs. Examples of support for specific cultural preferences show that service providers are putting essential values of appropriate care for ethnic minorities into practice, including the right to personal choice and respect for cultural preferences; however, shortcomings still persist (Bowes et al. 2008, 2011, Wilkinson 2009, Manthorpe et al. 2010). Underpinning this is the increasing focus on person-centred or individualised care. Additionally, identified gaps in service provision have been highlighted, including 'colour-blind' approaches to service provision, little choice of care options, lack of understanding of clients' cultural needs,

information not provided in clients' own language, inadequate provision of language support services, and an over reliance on family interpreters (Gerrish 2001, Patel 2003, Bowes et al. 2008, 2011).

In line with our work on seeking views of older women from BME backgrounds and their experiences of good quality of care, in this research[2], we aim to build a wider picture in this area from the perspectives of service providers. Importantly, the focus is not on nursing or health care settings, but on domiciliary care and community-based support. Quality of care depends on an awareness and responsiveness to people's needs and expectations. Moreover, dignity has a structural dimension, as well as an interpersonal dimension, both of which are constructed by the act (or lack) of recognition (Saltus & Folkes, in press). The perceptions of care drawn from service providers working in a multicultural or intercultural context will allow us to begin to examine perceptions that are grounded in personal experiences and perceptions, as well as shaped by broader expectations of professional and organisational practice (Gunaratnam 2011). The evidence drawn from this study will be rooted in perceptions of service providers and of the responsiveness of their services to deliver care and support to its client base, with a specific focus on how care and support are provided to older women from minority ethnic groups. The results will be useful and important for the planning and delivery of appropriate services for older people, in exploring how service providers are seeking to provide culturally responsive services, how challenges and barriers are being addressed and also in mapping areas where further research is needed.

[2] The other outputs from this study: In their Own Words Study: Profile of the selected population groups (Downes & Saltus 2011), and Capturing the voices of older women from Black Caribbean, Chinese, Bangladeshi and Indian backgrounds in order to understand their perceptions of dignity, with a focus on care and support (Saltus 2012)

2. Aims and objectives

The aim of this study was to explore service providers' perceptions of how dignity and high quality care can be enhanced or diminished, with a focus on care and support offered to older women from a BME background. The following questions were addressed:

1. What were service providers' perceptions of how older women from a BME background viewed the care and support they received?
2. What were the barriers to and facilitators of providing high quality of care and support for older women from a BME background?
3. What were the resources available for service providers to draw on in their everyday practice to provide better care and support of older women from a BME background?

3. Research methods

3.1 Design

A survey design was applied using a purposely developed questionnaire to capture service providers' perceptions. This design is common in studies and evaluations of health and social care services, and was thought to be best suited to measure and compare the views and opinions of service providers in this study.

3.2 Research settings

The research was conducted in Wales, with a focus on service providers based in voluntary, statutory and private sectors. In Wales, social services and social care are delivered by the 22 local authorities, as well as around 1800 private and independent organisations, supporting 150,000 people of all age and ethnic groups (http://wales.gov.uk/topics/health/socialcare/?lang=en). As noted previously, in Wales, as in other parts of the UK, there is an increasingly ageing population. According to the

2011 Census, the population in Wales was 3.06 million in 2011, and the percentage of its population aged 65 and over was at over 18%, accounting for 560,000 people (ONS 2012). The percentage of people from a BME background in Wales increased from 2.1% to 4.1% between 2001 and 2009, with Asian or Asian British being the largest minority ethnic group, accounting for 1.8% Wales' population in 2009 (WG 2011). Cardiff, Newport, the Vale of Glamorgan and Swansea had the highest proportions of ethnic minorities in 2009 (WG 2011).

3.3 Sample and sampling

People eligible for the study were those in Wales who (i) delivered hands on care or support to older people (50 years and older) living in their own homes, (ii) supervised others delivering such services, or (iii) managed such services. Those invited to take part included service providers delivering community-based services (i.e. dinner clubs, women's community/support groups, and advocates), good neighbour scheme coordinators and volunteers, reablement/settlement workers, welfare rights support workers, supported shopping workers, and those providing domiciliary care.

A cascade approach was taken to recruit respondents. An invitation to participate was sent to various key local, regional and national organisations, e-groups and networks in contact with older people or with a specific remit to work with minority ethnic population groups. Information was circulated via emailing lists, bulletins or newsletters of these organisations or groups. Special attention was made to target BME user-led and voluntary social care services, BME women's groups and organisations, and key organisations with expertise in issues around older people, and people or older women from a BME background. Other strategies included the use of social media sites, such as Twitter and Facebook sites, and snowballing techniques where respondents were asked to forward the survey information on to any of their contacts who might be interested. Table 1 illustrates the detailed sampling process.

Table 1: The sampling process

Strategies	Organisations/groups	Examples
Via email	Public sectors	Local authorities All Wales Adult Service Heads Equality and Diversity Officers Older People's Strategy Coordinators
	Private sectors	A list of domiciliary care providers
	Voluntary sectors	Local Age Cymru/Concerns Minority Ethnic Women's Network Women Connect First Wales Council for Voluntary Action
	E-groups	Age Alliance Wales JISCMail Minority Ethnic Health JISCMail Older People JISCMail Wales Ethnicity Research Collaboration Older People & Ageing Research & Development Network
Via bulletin/newsletters	Networks	Carers Wales Dignified Revolution Older Minority Ethnic Network Care and Social Services Inspectorate Wales Older People's Commissioner for Wales UK Home Care Association
Via social media	Websites	Wales Ethnicity Research Collaboration: http://www.werconline.org.uk/itow/survey.php Dignified Revolution: http://dignifiedrevolution.org.uk/
	Twitter & Facebook	Faculty of Health, Sport and Science University of Glamorgan
Via snowballing		Asked all respondents to forward the survey information to any contacts who might be interested

3.4 Data collection

A questionnaire was developed to explore service providers' experiences of service delivery and their perceptions of how people, especially older women from a BME background, viewed the care or support they received. The questionnaire development was informed by the literature on good quality of care for older people (e.g. Gallagher et al. 2008, Magee et al. 2008), literature on dignity in care (e.g. Levenson 2007, Tadd et al. 2011), policy documents (DH 2001, WG 2006), and advisory meetings with stakeholders.

The questionnaire focused on two dignity indictors: (i) older people's involvement in the organisation of their care or support needs, and (ii) effective communication. This was due to the suggestion that it is important not to explore all dignity indicators at one time, but to focus on exploring whether care is being delivered in a dignified way in one or two domains at any one time (Magee et al. 2008).

The questionnaire consisted of 35 questions that addressed the following topics:

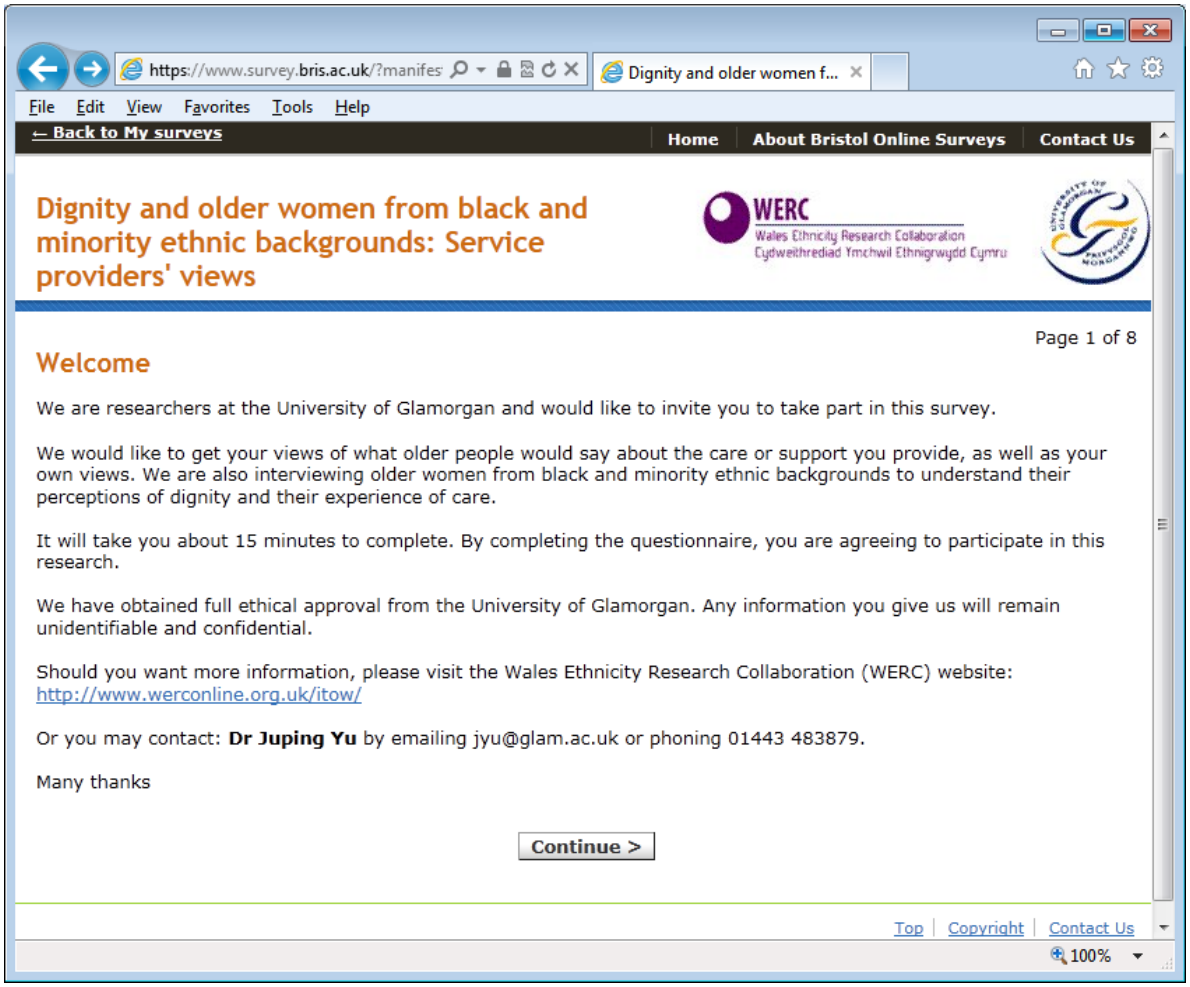
- demographic information;
- information on respondents' organisation and practice;
- understanding of the concept of dignity;
- perceptions on how older women from a BME background perceived the care or support they received;
- views on how older women from a BME background felt they were understood when talking about their care or support requirements;
- perceived barriers to, and facilitators, of service provision, and
- examples of effective practices and services.

The questionnaire was available in both online and paper formats. Most questions were closed with fixed responses, and there were a few open questions with spaces for respondents to add free text expressing their perceptions and opinions in their own words. The questionnaire was developed over a four-month period. The content and face validity was piloted between January and February 2012 with a group of 12 people who had expertise in older people's issues, questionnaire design or statistics. The questionnaire was refined with feedback received on aspects of its content, readability, flows, layout and technique issues.

Data were collected between March and June 2012. The Bristol Online Survey website, an online survey engine, was used to host the survey (Figure 1). An invitation email with a link to the survey site was sent out to interest organisations and individuals (https://www.survey.glam.ac.uk/dignitybme). There was no requirement to log on to the site in order to take part. With all questions optional, respondents were not forced to give answers to the questions they might want to skip. Three contacts were made by email,

with an initial contact and two follow-up reminders at 4-week intervals. In total, 97 responses were received online.

Figure 1: Screen shot of the survey website



A copy of the questionnaire as a PDF file was attached to all invitations sent by email in case some people preferred to fill in the questionnaire as a printed copy. A hard copy was also available on request, and some were sent to people who agreed in advance to help distribute them. This was also due to the consideration that some potential respondents such as front line service providers might have limited access to Internet at work on a daily basis. Each copy was accompanied by an information sheet and a freepost envelope with address for return of the questionnaire. Twenty-seven hard copies were returned by post.

In the questionnaire, respondents were asked whether they were willing to take part in a telephone discussion to provide further information on their practice and services. A template was used to collate the responses made in these discussions. In total, 14 respondents participated in a discussion.

3.5 Data analysis

The questionnaires were analysed between July and September 2012. All survey data were entered and analysed in SPSS version 19, a quantitative data analysis software package. Data collected online were downloaded and imported directly and those collected via paper copies were entered manually. A descriptive statistical analysis was conducted to describe frequencies and percentages of variables. Inferential statistical analysis was also performed to explore associations between variables using Chi square tests and Wilcoxon tests. Statistical significance was set at 0.05 (two-tailed) for all statistical analysis. In some cases, comparisons between older BME women (as well as BME older people in general) were made with 'older people in general' (a phrase used to connote the wider older population grouping).

Data collected as free text in the survey were analysed thematically, using NVivo10. Notably, 113 responses were received on the question asking respondents to list any words or phrases that came to mind when hearing the word 'dignity'. For this particular question, a word frequency query was run to identify and discuss the words that were most significant in relation to respondents' understanding of dignity. In addition, the summaries of services and practices captured in the telephone discussions with 14 respondents were also analysed thematically.

3.6 Ethical considerations

The research was approved by the research ethics committee of the Faculty of Health, Sport and Science, University of Glamorgan. General ethical principles in health and social care were followed. Participation was voluntary with no money or any incentive

given. Submission of a completed questionnaire online or returning it as a hard copy by post was considered an indication of consent.

Elements that would normally be part of the consent process were made available. First, an information sheet was provided fully explaining the study purpose, the nature of participation and contact details. An electronic copy of this information was attached to every invitation sent by email, while a hard copy was attached to each paper copy of the questionnaire. In addition, a link was provided on the first webpage of the online survey site, directing users to a website where a copy could be downloaded along with other information about the study. Second, the availability of researchers' contact details offered prospective respondents an opportunity to raise questions so that they could make an informed decision about participation, as well as allowed any experiences of difficulties in completing the questionnaire to be reported. Third, respondents were informed of their right to withdraw without giving reasons. Capability to navigate away from any web pages while participating online provided greater protection for people who wished to withdraw. The option to complete the questionnaire online or as a paper copy offered people more choices and flexibility. Respondents were assured that any information they provided remained unidentifiable, with anonymity and confidentiality preserved in data analysis and reports. Respondents were not asked to provide their contact details unless they wished to take part in a follow up discussion on examples of good practice.

PART TWO

4. Results

4.1 The Respondents

In total, 124 replies were received. Table 2 shows self-reported demographic information in terms of gender, age and educational qualifications, and Table 3 illustrates their self-reported ethnicity. Most respondents were female (n=108, 89.3%) from a white background (n=96, 81.4%). The largest proportion of respondents was in the 46-55-years group (n=48, 39.7%), and more than half of the respondents were educated at degree level and above.

Table 2: Self-reported demographic information

Self-reported information		**Frequency**	**Percentage***
Gender	Male	13	10.7
	Female	108	89.3
Age (year)	Under 25	1	0.8
	25-35	17	14.0
	36-45	26	21.5
	46-55	48	39.7
	56-65	27	22.3
	Over 65	2	1.7
Educational level	Certificate	13	11.0
	Diploma	34	28.8
	Bachelor's degree	27	22.9
	Graduate diploma	14	11.9
	Masters degree and above	25	21.2
	None of the above	5	4.2

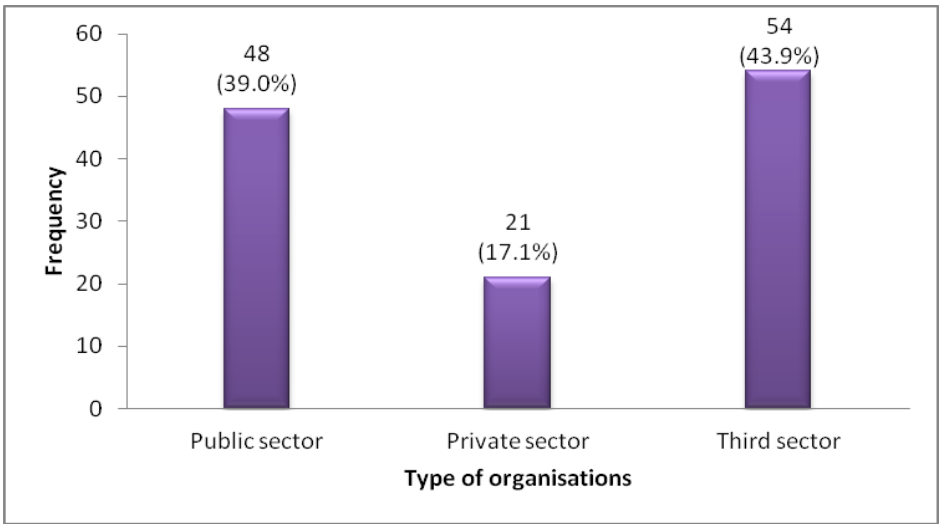
* Some information was not provided by all participants.

Table 3: Self-reported ethnic background

	Frequency	Percentage
White Welsh	58	49.2
White British	35	29.7
Chinese	9	7.6
Black or Black British - African	4	3.4
Other White background	2	1.7
Asian or Asian British - Indian	2	1.7
Asian or Asian British - Pakistani	2	1.7
Any other Asian background	2	1.7
White Irish	1	0.8
Black or Black British – Caribbean	1	0.8
Asian or Asian British - Bangladeshi	1	0.8
Any other mixed background	1	0.8
Total	**118**	**100**

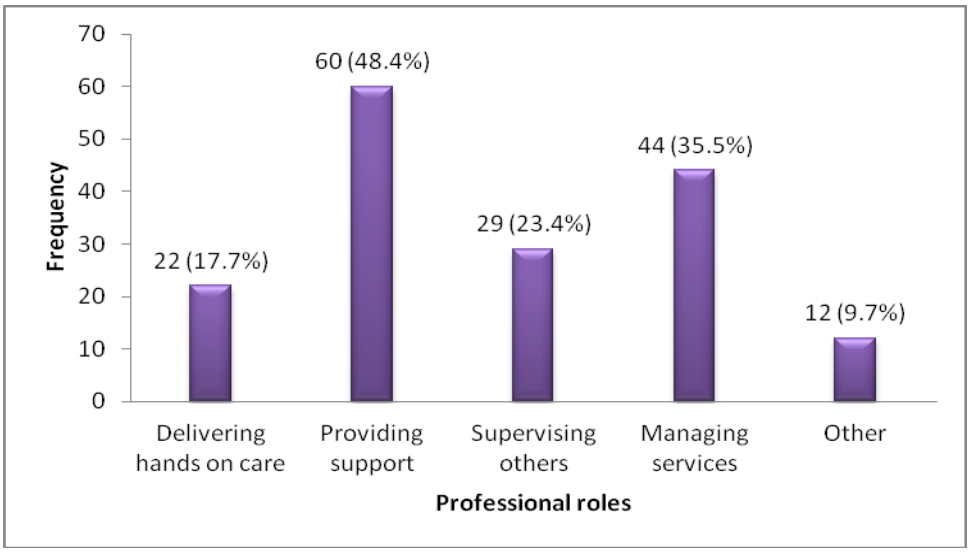
We aimed to achieve Wales-wide coverage. Fifteen respondents (12.1%) indicated that they worked on an all-Wales basis, and the rest worked either regionally or locally. The majority of respondents were based in South Wales, with Cardiff (n=31, 25%) being the most frequently reported local authority, followed by Swansea (n=20, 16.1%) and Vale of Glamorgan (n=17, 13.7%). Twenty-six respondents (21%) reported that their practice covered one of the six local authorities in North Wales. In terms of the sub-sectors from which the sample was drawn, the largest proportion of respondents (n=54, 43.9%) worked in the third sector, followed by the public sector and the private sector (Figure 2). Respondents from a BME background comprised 18.6% of the sample, and the majority of them (68.2%) worked in the third sector.

Figure 2: The sectors in which respondents worked



Regarding respondents' professional role, some reported that they were involved in more than one role. The largest proportion was involved in providing support, followed by managing services and supervising others (Figure 3). A small number of respondents were also involved in other roles such as providing support to people with learning disability, deaf or blind, but not necessarily older people. The length of time respondents had been in their roles varied, ranging from less than a year to over 40 years, with a mean of 11.31 years (SD = 9.203).

Figure 3: Respondents' professional roles



Fifty-five percent of respondents (n=67) reported that in the past 12 months, they had seldom or never provided care or support to older people from a BME background. Of those who did, the majority had always or frequently worked with both men and women. Of those who had worked with women from a BME background, their main roles included delivering hands on care (n=11), providing support (n=35), supervising others (n=16), or managing services (n=23), and some had more than one role. Chi square tests were performed in order to determine whether different sectors were associated with what care or support respondents provided (Table 4). Respondents in the public sector most often reported that their organisations provided intermediate/reablement care and day care (p=0.006, p=0.045, respectively). Respondents in the private sector were statistically most likely to report that their organisations provided home based care (p=0.011), while

the provision of advocacy was most often identified by those in the third sector (p=0.001).

Table 4: Types of care and support provided by the public, private and third sector

	Home based care	**Intermediate care / reablement care**	**Day care**	**Community based support**	**Advocacy**	**Welfare**	**Other**
Public sector	23 (47.9%)	17 (35.4%)	16 (33.3%)	34 (70.8%)	9 (18.8%)	12 (25%)	8 (16.7%)
Private sector	12 (60%)	4 (20%)	4 (20%)	9 (45%)	1 (5%)	4 (20%)	3 (15%)
Third sector	14 (25.9%)	5 (9.3%)	7 (13%)	39 (72.2%)	20 (37.3%)	13 (24.1%)	2 (4.9%)
χ^2	9.03	10.393	6.182	5.378	13.12	0.2	4.96
P value	0.011*	0.006*	0.045*	0.068	0.001*	0.905	0.084

Chi square tests, 2–tailed, * significant result

4.2 Meaning of dignity

This section contains analysis of 113 responses to the question: *Please list any words or phrases that come to mind when you hear the word dignity*. The analysis included a word frequency query to identify and discuss the words that were most significant in relation to respondents' understanding of dignity. Respect was mentioned most frequently with regards to dignity. Broadly speaking, respondents acknowledged that care with dignity meant ensuring one's care and support needs were met in a respectful way. Respect was strongly associated with dignity, and was communicated, or manifested itself through actions and behaviours.

Acts of respect that enhanced the delivery of care or support were understood as being engendered through interpersonal interaction. Respondents described the optimal way in which people should be treated equally, fairly and respectfully, irrespective of differences in age or ethnicity. Dignity was conferred or enhanced when behaviours or actions demonstrated respect for privacy, individuality, preferences and choices, particularly in relation to culture, religion and values. Some respondents simply quoted the maxim 'treat others as you would wish to be treated'. Behaviours which could be described as

insulting, condescending and abusive were identified by respondents as disrespectful and actions that diminished a person's sense of dignity.

In keeping with prevalent professional care narratives, dignity for the respondents was also closely associated with their professional conduct. Within the context of the delivery, appropriate care and support that was understood as being underpinned by notions of equality, empathy, compassion, empowerment, kindness, politeness, non-judgement, confidentiality and professionalism. Moreover, the perspective that people should be viewed and treated as an individual was repeated often and appeared to contribute to respondents' understanding of how care was experienced. Among the responses, there were many references to dignity in relation to the self, including, self-respect, self-esteem, self-worth, self-importance, self-confidence, pride, and self-awareness. Respondents were aware that how people were perceived had implications for how they were treated in relation to dignity. A person-centred or individualised care was regarded by some as the best approach to ensuring dignity of identity and many respondents singled out person-centred care in their responses.

4.3 Perceptions of older women's views on their care and support requirements

4.3.1 The opportunity and support to express care needs

Respondents were asked about their perceptions of how often older people would think they were offered the opportunity and the support to express their needs. Although most of respondents perceived that older women from a BME background would think they were always or frequently offered the opportunity and the support to express their care needs and requirements, twenty-two percent of respondents perceived that the opportunity was seldom offered and 7.7% thought they were seldom supported to do so (Table 5). A slightly greater number of respondents perceived that other segments of the older population would be always frequently offered the opportunity or support to express their care needs and requirement.

Table 5: Perceptions of opportunity or support to express care needs

		Always	Frequently	Seldom
Being offered the opportunity to express their needs	Older women from a BME background	44 (41.4%)	41 (37.6%)	24 (22%)
	Older people in general	58 (46.8%)	51 (41.1%)	15 (12.1%)
Being supported to express their needs	Older women from a BME background	41 (45.1%)	43 (47.3%)	7 (7.7%)
	Older people in general	56 (50%)	49 (43.8%)	7 (6.3%)

Wilcoxon tests were conducted to check whether there were differences between respondents' perceptions of older women from a BME background and older people in general, in terms of having the opportunity to express their needs and also being offered support in order to do so. The majority of respondents suggested that the opportunity was offered at the same level to older women from a BME background and older people in general. However, some perceived that older women from a BME background were offered the opportunity less often than older people in general, a statistically significant result ($p=0.002$). In terms of being offered support to express their needs, there was no statistically significant difference between responses referring to the two groups ($p=0.495$).

The frequency of providing care or support to older women from a BME background did not affect respondents perceptions of the opportunity or support offered (both $p>0.05$). In terms of the different organisations, there was a weak trend whereby respondents in the private sector were more likely than those in any other sectors to believe that older women from a BME background would think they were supported**.** 62.5% perceived that they were always supported, while those from the public sector were less likely to report so, with only 38.8% perceiving they were always supported. However, the difference was not statistically significant ($\chi^2=7.05$, $p=0.133$), and this area is in need of further study with a larger sample.

4.3.2 Addressing key care requirements

Questions were asked about respondents' perceptions of how people would think their needs were addressed, in terms of physical needs, cultural beliefs, religious beliefs, psychological needs and social needs (Table 6). Respondents perceived that older women

from a BME background, like older people in general, would think their physical needs were most often taken into account, compared to other needs. The cultural beliefs of older women from a BME background were thought to be the least often taken into account. Such responses were not associated with the frequency of working with older women from a BME background ($p>0.05$).

Table 6: Perceptions of how often the care needs are addressed

	Older women from a BME background		**Older people in general**	
	Always/frequently taken into account	Seldom/never taken into account	Always/frequently taken into account	Seldom/never taken into account
Physical needs	88 (90.7%)	9 (9.3%)	108 (92.3%)	9 (7.7%)
Social needs	74 (77.1%)	22 (22.9%)	98 (85.2%)	17 (14.8%)
Psychological needs	70 (74.5%)	24 (25.5%)	90 (78.9%)	24 (21.1%)
Religious beliefs	61 (66.3%)	31 (33.7%)	81 (73%)	30 (27%)
Cultural beliefs	58 (63%)	34 (37%)	85 (74.6%)	29 (25.4%)
χ^2	77.546		74.718	
P values	<0.0001*		<0.0001*	

Chi square tests, 2-tailed, * significant result

Wilcoxon tests were conducted to check whether there were differences between respondents' perceptions of older women from a BME background and older people in general, in terms of their needs being taken into account (Table 7). Of those who answered the sets of questions, the majority of respondents suggested that the needs were taken into account at the same level for older women from a BME background and older people in general. Where there were differences in perception, they reported that older women from a BME background had their needs taken into account less often than older people in general. These results were statistically significant, in the case of physical, cultural, psychological and social needs ($p<0.05$). For religious beliefs, there was a weak effect, which was not statistically significant ($p=0.085$).

Table 7: Perceptions of care needs being taken into account

	Perceived the same in terms of BME older women and older people in general	Less likely to perceived that BME older women's needs were taken into account	More likely to perceived that BME older women's needs were taken into account	Z	P value
Physical Needs	86	10	0	-3.051	0.002*
Cultural beliefs	73	17	1	-3.710	<0.001*
Religious beliefs	67	17	6	-1.720	0.085
Psychological needs	81	10	2	-2.324	0.020*
Social needs	80	12	3	-2.357	0.018*

Wilcoxon's signed ranks test, 2-tailed, *significant result

4.4 Perceptions of care involvement

Questions were asked that explored respondents' perceptions of older people's involvement in care. Of the 121 respondents, the majority perceived that older people in general and older women from a BME background would think they were always or frequently involved in decision making about their care (Table 8). However, 27.8% perceived that older women from a BME background were seldom or never involved in decision-making about their own care, compared with 18.2% who perceived that older people in general were seldom or never involved.

Table 8: Perceptions of extent of involvement decision making

	Always (N/%)	Frequently (N/%)	Seldom (N/%)	Never (N/%)
Older women from a BME background	34 (31.5%)	44 (40.7%)	27 (25%)	3 (2.8%)
Older people in general	43 (35.5%)	56 (46.3%)	20 (16.5%)	2 (1.7%)

A Wilcoxon test was conducted to compare respondents' perceptions in relation to older women from a BME background and older people in general, in terms of their involvement in their own care. Of 108 respondents who answered the set of questions, the majority (n=96) gave the same answer. However, of 12 respondents who did not, they

were less likely to perceive that older women from a BME background were involved, with 11 reporting that older women from a BME background would think they were less often involved, and only one perceiving the opposite, a statistically significant result (Z=-2.84, p=0.005).

4.5 Effective communication

Effective communication - being listened to, being able to discuss care and support requirements, feeling satisfied that one's points have been understood and taken on board - is a key indicator underpinning many of the dimensions of dignity. With regards to choice of language, an important aspect of effective communication, 44.1% (49/111) of respondents perceived that older women from a BME background could seldom or never choose which language they wished to use to communicate. Also, 31.9% (37/116) believed that older women from a BME background were seldom or never provided with information relevant to their ethnic or cultural background. Neither perceptions were associated with types of organisations for which respondents worked, professional roles, how often they worked with older women from a BME background, or whether they were from a BME background themselves ($p>0.05$).

Also, respondents were asked about their perceptions of older people's agreement on six statements on effective communication (Table 9). The statement that produced the highest proportion of strongly agree/agree response for both groups (older population in general and older women from a BME background) was, 'I can discuss my care with people who support me' (85.1% and 80% respectively). The rank order of agreement with the other statements differed between the older population in general and older women from a BME background as follows: for 'People who provide care or support to me take time to listen to what I have to say' rates were 80% and 74.3% respectively; for 'People who provide care or support to me listen carefully to what I have to say', rates were 79.3% and 71.5% respectively; for 'People who provide care or support to me make

Table 9: Perceptions of effective communication

	Older women from a BME background					**Older people in general**				
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
I have been asked how I would like to be addressed.	41/109 (37.6%)	41/109 (37.6%)	17 (15.6%)	8 (7.3%)	2 (1.8%)	49/120 (40.8%)	42 (35.0%)	21 (17.5%)	6 (5.0%)	2 (1.7%)
I can discuss my care with people who support me.	43/110 (39.1%)	45 (40.9%)	17 (15.5%)	4 (3.6%)	1 (0.9%)	56/121 (46.3%)	47 (38.8%)	14 (11.6%)	4 (3.3%)	-
People who provide care or support to me listen carefully to what I have to say.	42 /109 (38.5%)	36 (33.0%)	24 (22.0%)	4 (3.7%)	3 (2.8%)	49/121 (40.5%)	47 (38.8%)	21 (17.4%)	3 (2.5%)	1 (0.8%)
People who provide care or support to me take time to listen to what I have to say.	37/109 (33.9%)	44 (40.4%)	22 (20.2%)	3 (2.8%)	3 (2.8%)	48/120 (40.0%)	48 (40.0%)	20 (16.7%)	2 (1.7%)	2 (1.7%)
People who provide care or support to me make sure I understand them.	36/107 (33.6%)	39 (36.4%)	22 (20.6%)	8 (7.5%)	2 (1.9%)	47/119 (39.5%)	45 (37.8%)	18 (15.1%)	8 (6.7%)	1 (0.8%)
I am comfortable to raise concerns about my care.	34/107 (31.8%)	40 (37.4%)	23 (21.5%)	6 (5.6%)	4 (3.7%)	43/120 (35.8%)	40 (33.3%)	26 (21.7%)	7 (5.8%)	4 (3.3%)

sure I understand them' rates were 77.3% and 70% respectively; and for 'I have been asked how I would like to be addressed' rates were 75.8% and 75.2% respectively. The statement that produced the lowest proportion of strongly agree/agree response for both groups was 'I am comfortable to raise concerns about my care'. For this statement the rates were markedly lower and, in this instance, very nearly the same (69.1% and 69.2% respectively).

The survey revealed that effective communication, although in some areas rated highly, was still of concern, notably for those who spoke languages other than English. Moreover, although the majority of the respondents perceived that older people felt that time was given and consideration was taken to listen and respond to the care or support requirements articulated by the older people they worked with, the number of 'neither agree or disagree' responses which does raise effective communication as an area in need of further investigation.

4.6 Challenges to providing care or support

Questions were asked about barriers to providing general care or support services to older women from a BME background, and specific barriers to delivering hands on care, or organising services. The specific barriers were drawn from the research evidence base in the area; our aim was to explore if the known barriers were still relevant and also to explore any service-level challenges that could be identified from particular segments of the sample.

4.6.1 Key barriers

All respondents were asked about their perceptions of barriers or challenges which made it difficult for them to provide responsive care or support services (Table 10). The top five barriers were:

- lack of staff who can speak community language (70%)
- lack of interpretation services or limited access to interpreters (43.3%)

- lack of staff training (39.2%)
- limited time (38.3%) and
- not recognising the culturally specific needs of older people (37.5%).

Table 10: Barriers to the delivery of care or support services

Barrier	Frequency	Percentage
Lack of staff who can speak community languages	84	70.0
Lack of interpretation services/limited access to interpreters	52	43.3
Lack of staff training	47	39.2
Limited time	46	38.3
Not recognising culturally specific needs of older people	45	37.5
Lack of knowledge of older people's religious beliefs	42	35.0
Older people's perceptions of local services	38	31.7
Older people's lack of access to information	33	27.5
Older people's perceptions of local councils	27	22.5
Negative attitudes towards people from a BME background	17	14.2
Other	15	14.2
Racism	14	11.7
Negative attitudes towards older people	11	9.2
Negative attitudes towards women	4	3.3

Barriers linked to the service-level issues ranked highly, followed by issues linked to skills and competencies needed to work responsively in an intercultural context. Attitudinal and wider structural barriers such as racism, and negative attitudes towards groups of people based on age, gender or ethnicity were not ranked highly by the great majority of the respondents. It is noteworthy that respondents in the third sector were more likely than those in public sector and private sector to report negative attitudes towards people from a BME background and racism as barriers (70.6%, 17.6% and 11.8%, χ^2=6.345, p=0.042; 71.4%, 7.1% and 21.4%, χ^2=7.356, p=0.025, respectively). In terms of professional roles, respondents whose role was involved providing support to older people (e.g. befriending, lunch clubs) were statistically more likely than those who were involved in any other roles to report the following barriers:

- negative attitudes towards people from a BME background (χ^2=4.234, p=0.04)
- lack of knowledge of older people's religious beliefs (χ^2=5.376, p=0.02)
- older people's lack of access to information (χ^2=6.705, p=0.01) and
- lack of interpretation services (χ^2=7.252, p=0.007).

4.6.2 Barriers specific to delivering hands on care or support

Respondents who provided hands on care or support were asked an additional question on specific challenges in terms of their relevance to their practice (Table 11). Of all the listed challenges, the lack of staff who can speak community languages and lack of interpretation services/limited access to interpreters were the two most commonly encountered barriers**,** with 73.1% and 62.7% of respondents respectively believing that they always or frequently made it difficult to deliver hands on care or support to older women whose first language was not English.

Table 11: Barriers to the delivery of hands on care or support

	Always/frequently	**Seldom/never**
Lack of staff who can speak community languages	38 (73.1%)	14 (26.9%)
Lack of interpretation services	32 (62.7%)	19 (37.3%)
Limited time	30 (62.5%)	18 (37.5%)
Not knowing the culturally specific needs of older people	23 (48.9%)	24 (51.1%)
Lack of staff training	20 (45.5%)	24 (54.5%)
Lack of supervision and support	11 (27.5%)	29 (72.5%)

Chi square tests were conducted to explore whether their responses were associated with other variables. Gender, type of organisations, professional roles, and frequency of working with older women from a BME background did not have an effect ($p>0.05$). However, respondents from a BME background were statistically more likely than white respondents to report lack of staff training as a barrier (71.4% vs 34.5%, $\chi^2=5.180$, $p=0.023$).

4.6.3 Challenges to the effective organisation of responsive services

Respondents with a supervisory or managerial role were also asked an additional question on barriers to the organisation of services (Table 12). Of a list of barriers informed by existing literature, the two barriers most commonly reported by 53% of respondents in both cases were the way local services were accessed, and older people's culturally

specific needs not being taken into account when designing services. Attitudinal barriers, such as racism and negative attitudes to women or people from a BME background, were not often reported.

Table 12: Barriers to the organisation of services

	Always/frequently	**Seldom/never**
The way local services are accessed	34 (53.1%)	30 (46.9%)
Not taking in account of older people's culturally specific needs when designing services	44 (53%)	39 (47%)
Not taking in account of older people's culturally specific needs when evaluating services	41 (50%)	41 (50%)
Not taking in account of older people's culturally specific needs when commissioning services	40 (48.8%)	42 (51.2%)
The way local services are perceived	35 (44.9%)	43 (55.1%)
Negative attitudes to older people	12 (16%)	63 (84%)
Negative attitudes to people from a BME background	11 (14.7%)	64 (85.3%)
Negative attitudes to women	9 (12.2%)	65 (87.8%)
Racism	9 (12.2%)	65 (87.8%)

Chi square tests were also conducted to explore whether their responses were associated with other variables. Gender, different organisations, frequency of caring or supporting older women from a BME background, did not have an effect ($p>0.05$). However, respondents from a BME background were statistically more likely than white respondents to report racism as a barrier (41.7% vs 6.5%, $\chi^2=11.671$, $p=0.001$).

4.7 Responsive care and support: source of information and key facilitators

One section of the survey covered questions about where respondents accessed key sources of information on how best to provide care and support to service users. Questions were also asked on facilitators that promoted quality care and dignity.

4.7.1 Information pathways

Six sources relating to internal access paths to information, knowledge and support were presented, namely care plan, co-workers, supervisors, managers, internal policy, and best

practice guidelines (Table 13). Some respondents identified use of more than one source. The best practice guidelines were most frequently reported as the top source of information (57.6%), followed by internal policy (50.8%), and information provided by a line manager (50%). Managers as well as care plans, internal policy and best practice guidelines were seen as sources of care information for over 50% of respondents with a supervisory or managerial role. Best practice guidelines were seen as a source of care information for over 50% of respondents in third sectors.

Table 13: Key sources of information, knowledge and support

	All respondents	**Respondents delivering hands on care**	**Respondents with a supervisory or managerial role**	**Respondents working in third sectors**
Care plan	40.7%	68.2%	61.5%	19.6%
Co-workers	41.5%	54.5	46.2%	43.1%
Supervisors	30.5%	40.9%	28.8%	27.5%
Mangers	50%	63.6%	55.8%	49%
Internal policy	50.8%	72.7%	59.6%	45.1%
Best practice guidelines	57.6%	68.2%	65.4%	54.9%
Other	3.4%	4.5%	1.9%	0%

Chi square tests were conducted to check whether these sources were associated with other variables. Gender, ethnic categories, and frequency of working with older women from a BME background did not have an effect ($p>0.05$). However there were notable differences in relation to professional roles and organisations. Respondents who delivered hands on care and those with a supervisory or managerial role were more likely to go to a care plan for information (68.2% vs 34.4%, $\chi^2=8.477$, $p=0.004$), (61.5% vs 24.2%, $\chi^2=16.765$, $p<0.0001$). Respondents delivering hands on care were also more likely to go to internal policy (72.7% vs 45.8%, $\chi^2=5.18$, $p=0.023$). In addition, respondents in the private sector were more likely than those in public or third sectors to go to care plan for information (76.2%, 48.9% & 19.6%, $\chi^2=21.552$, $p<0.0001$).

Questions were asked on where respondents sourced support and information from external organisations, with seven sources listed for consideration (Table 14). Respondents were asked to identify all those on the list they had approached. Organisations that mainly work with older people were reported as the top source,

referred to by over half of all respondents. This was closely followed by organisations providing health and social care, and organisations mainly working with older people from a BME background, all of which were referred to by around half of all respondents. Equality organisations and cultural associations were referred to by around a third of the respondents.

Table 14: External sources of support

External organisation	Frequency	Percentage
Organisations mainly working with older people	64	53.8
Organisations providing health and social care	62	52.1
Organisations mainly working with older people from a BME background	57	47.9
Equality organisations	44	37.0
Cultural associations	37	31.1
Organisations mainly working with women from a BME background	32	26.9
Religious organisations	27	22.7
Other	20	16.1

Chi square tests were performed to check whether respondents' responses were associated with other variables. No significant results were found with regards to gender, ethnic categories, and organisations ($p>0.05$). However, professional role had an effect as respondents with a supervisory or managerial role were more likely to use religious organisations (32.1% vs 15.2%, $\chi^2=4.8$, $p=0.028$).

In seeking to capture other sources or pathways to information, a list of options other than organisations were also presented (Table 15). Reported by 72.5% of respondents, family members and friends of the person respondents proved care or support for were most frequently referred. This was followed by seeking information from the person they provided care or support for (67.5%) and drawing on their own experiences (55%).

Table 15: Other key sources of information and support

	Frequency	Percentage
Family members and friends of the person you provide care or support for	87	72.5
The person you providing care and support for	81	67.5
Own experience	66	55.0
Multi-cultural sources	52	43.3
Independent advocacy	42	35.0
Books, journals or magazines	38	31.7
Religious sources	25	20.8
Other	18	14.5
Online training	16	13.3
Online discussion forum	8	6.7

Chi square tests were performed to check whether respondents' responses were related to gender, ethnic categories, different organisations, and professional roles. Gender and organisations did not have an effect ($p>0.05$). However, respondents from a BME background were statistically more likely than white respondents to report the use of their own experiences (90.9% vs 50.0%, $\chi^2=12.189$, $p<0.0001$). Respondents providing hands on care were more likely to go to online training for information (27.3% vs 10.2%, $\chi^2=4.530$, $p=0.033$); those with a supervisory or managerial role were more likely to approach family members and friends of the person they provided care or support for (84.9% vs 62.7%, $\chi^2=7.327$, $p=0.007$).

4.7.2 Facilitators of care with dignity

Respondents were asked to identify elements which might enhance their care or support practices. Seven elements were listed for consideration (Table 16). Staff training was most frequently reported, being referred by 60% of the respondents**.** Other elements referred by over half of the respondents were by the recognition of older people's needs, receiving information tailored to older people's needs, displaying positive attitudes to BME older people, and the availability of interpreters.

Table 16: Key elements that might help respondents provide better services

	Frequency	Percentage
Staff training	72	60.0
Recognition of older people's needs	70	58.3
Information tailored to older people's needs	70	58.3
Positive attitudes to BME older people	67	55.8
Availability of interpreters	66	55.0
Willingness to take action on older people's needs	56	46.7
Organisational culture	45	37.5
Other	11	9.2

Chi square tests were performed to check whether respondents' responses were associated with other variables. There were no effects in terms of gender or organisations ($p>0.05$), but professionals roles, frequency of working with older women from a BME background and ethnic categories did. Respondents with a supervisory or managerial role were more likely to report staff training as the key element (71.7% vs 50.7%, $\chi^2=5.413$, $p=0.02$). Respondents who had often provided care or support to older women from a BME background were more likely to report information tailored to older people's needs and availability of interpreters as key elements (65.2% vs 27.8%, $\chi^2=8.066$, $p=0.005$; 63.6% vs 22.2%, $\chi^2=9.792$, $p=0.002$, respectively)**.** Respondents from a BME background were statistically more likely than white respondents to report the following five elements (Table 17):

- organisational culture ($p=0.006$)
- positive attitudes to older people from a BME background ($p=0.01$)
- recognition of older people's needs ($p=0.001$)
- willingness to take action on older people's needs ($p=0.002$), and
- information tailored to older people's needs ($p=0.005$)

Table 17: Comparison of key enhancers of care or support across broad ethnic groupings

	BME respondents (n=22)	**White respondents (n=93)**	**χ^2**	**P values**
Organisational culture	14 (63.6%)	30 (32.3%)	7.416	0.006*
Positive attitudes to BME older people	18 (81.8%)	48 (51.6%)	6.638	0.01*
Recognition of older people's needs	20 (90.9%)	49 (52.7%)	10.829	0.001*
Willingness to take action on older people's needs	17 (77.3%)	38 (40.9%)	9.453	0.002*
Information tailored to older people's needs	19 (83.4%)	50 (53.8%)	7.878	0.005*
Availability of interpreters	16 (72.7%)	49 (52.7%)	2.907	0.088
Staff training	15 (68.2%)	56 (60.2%)	0.478	0.489

Chi square tests, 2-tailed, * significant result

4.8 Follow-on telephone discussions

As part of the survey, we requested examples of good practice. In total, 14 respondents, 11 females and 3 males, across the public, private and third sectors took part in a telephone discussion after the survey. In the discussions that took place between May and June 2012, they shared information about their experiences of service provision for older people, highlighting what they did well and some challenges they had encountered. Most respondents were from South East and North Wales areas, and mainly provided services which supported a specific group of people, such as people with disability and homeless people. None of them worked solely or significantly with older people from a BME background, and most services were provided to people across all age and ethnic groups.

Most respondents indicated that their services had been evaluated in some way. Monitoring mechanisms varied, with the use of either internal or external evaluation, or both. These mainly included client feedback via regular postal surveys, self-monitoring, and reports to funders.

A template was used to frame the discussions and each conversation was summarised. What follows are key emergent themes drawn from the telephone discussions:

- The invisibility of older men and women from BME backgrounds
- The impact of the economic down-turn on service delivery
- Delivering responsive care in a intercultural context

The first theme centred on access and visibility. Respondents reported that there were often few referrals of BME users via social services or self-referrals. Service providers felt unsure how and where to approach BME users and acknowledged difficulties in informing older people of newly developed programmes or services. Moreover, most respondents thought that BME older people and their family members were often unaware of services, especially mainstream services available for them. They also thought that a social support network was often not in place to facilitate access to relevant services on older people's behalf. It was also highlighted that some stigma often deterred BME people from seeking help, such as that attached to not being able to look after a family member or having a member with certain conditions such as an impairment or dementia.

In addition, interpretation and translation services were thought not to be always accessible and affordable, and in some situations it was not appropriate, for example the presence of a third party during the provision of intimate care. Not being able to communicate made it very difficult to understand older people's needs or to establish a trust relationship. The use of diverse tools to overcome communication difficulties encountered with clients from a BME background was recommended. Tools respondents had already used to enhance communication included picture boards, interpreters, family members, sign language, and translation of care/case notes. Learning some simple minority language phrases and words was thought to be helpful as well.

The second key theme emerging from the telephone discussions was centred around barriers to service delivery. Unsurprisingly, the lack of funding was frequently seen as a key factor that had hindered the development and adaptation of support and care. The respondents perceived this to be even more of a pressing concern for those based in third

sector organisations. The current economic climate made it difficult to develop new initiatives such as recruiting and training workers who could specifically engage with particular population groups. Moreover, some perceived that the due to budget cuts, time allowed for each home visit was being shortened. In some cases, staff members had to rush in and out to get tasks done, leaving little time for interaction with clients.

The third emergent theme is linked to responsive care and working in a intercultural context. Among some respondents it was stressed that staff members tended to be constrained from learning about and responding to culturally appropriate care which often required more time and effort to plan and put into practice. Moreover, there was some reticence regarding if or how best to respond to requests that were made, for example, for matching (by ethnicity) service providers with older people. It was reported by some of the respondents that services for older people from a BME background would be more effective if provided by BME organisations, or if possible by matching BME service users with staff from the same background. Some respondents highlighted the value of visiting BME centres or services to learn a specific culture, and suggested the importance of consulting older people from a BME background about services and more outreach work to increase awareness of services available to them.

PART THREE

5. Discussion

The survey results should be understood within the context of some limitations. First, the aim was to capture the perceptions of service providers on the views held by older women they provided care or support to. Hence the views of the older person were 'once removed'; the respondents could only surmise their clients' views. Second, although the main focus was on older women from a minority ethnic background, the survey results provided evidence on the perceptions on the views held by service providers on the older population in Wales in general. We remain mindful however, of the fact that the use of the term 'older people' and the term 'older people in general', subsumes the great heterogeneity of the older population in Wales.

Third, based on the total number of social care providers in Wales, the sample size was small. This limits the generalisation of the findings and some significant associations observed might be occurred by chance. Moreover, male respondents were under represented with only 13 males in the study. This may reflect the demography of occupational groups involving in care settings. In addition, in the sample there were varying levels of experience of working with older people from a BME background, which may have impacted on their perceptions of how BME older women viewed care and support they received.

Fourth, the questionnaire used for data collection was presented in English only. In some occasions, we were requested the questionnaire in another language, such as Chinese. Organisations providing services to a specific ethnic community often employed staff from their own community who may or may not be proficient in English. We offered the opportunity to complete the questionnaire on telephone in another language, but nobody arranged to do so. Without the questionnaire being translated in other languages, we omitted some of these people's views. Another limitation is potential selection bias as respondents were self-selected. Those who returned a completed questionnaire online or by post might not representative of their groups due to the fact that they were likely to

have a particular interest in or concerns about dignity, which intrinsically motivated them to take part. Therefore, views from people with less interest in dignity and care for older people from a BME background might be underreported, and so did information on poor practice. Despite these limitations, the study does add to the empirical research evidence on the views service providers hold in regard to their care practices, and on the provision of care and support to an increasingly diverse client group.

First, dignity is increasingly understood as a key factor in the delivery of good-quality health and social care. The survey revealed that for the respondents, respect was strongly associated with dignity and was communicated, or manifested itself through actions and behaviours. In turn, acts of respect that enhanced the delivery of care or support were understood as being engendered through interpersonal interaction. Respondents described the optimal way in which people should be treated as being treated equally and fairly. In keeping with prevalent professional care narratives, dignity for the respondents was also closely associated with their professional conduct. Moreover, the perspective that people should be viewed and treated as an individual and this appeared to contribute to respondents' understanding of how care was experienced.

The literature confirms that dignity is strongly associated with respect and that it is communicated or manifests itself through the actions and behaviours of both the self and others (Jacelon et al. 2004, Anderberg 2007). Moreover, this association between dignity and acts of respect is very much in keeping with the professional discourses on dignity, the practice guidelines and directives, the messages underpinning dignity campaigns, and the principles underpinning health and social care policy agendas throughout the UK.

Dignity has a structural dimension, as well as an interpersonal dimension, both of which are constructed by the act of recognition. This element was not strongly evident in the respondent's responses. The need for the person-centred care agenda to remain attentive to wider structural factors remains a pressing issue, as a narrow focus on the person, without attention being given to the wider societal context in which care and support are offered, delivered and experienced could work to limit the development of necessary cultural competencies needed to engage and work in an intercultural context. There is a

need for service providers to be mindful of wider social structures of inequality that can shape how people make sense of concepts such as dignity and care and to recognise and be mindful of how ongoing social inequalities based in the intersections of age and ethnic minority can shape encounters where dignity is especially important, just as they impact on the lived experiences of older people (Saltus & Folkes, in press).

Second, the study was preoccupied with dignity indicators such as recognition and acknowledgement of autonomy, personal identity, participation and control, choice, effective communication, personal care, privacy and independence. The majority of the service providers who took part in the survey perceived that older women from a BME background, and indeed older people in general, were offered the opportunity and support to express their needs. There was a strong perception that such support was given and being experienced. However, it is evident that in areas where this was not the case, older women from a BME background fared less favourably than the wider older population. The survey revealed that between 20% and 30% of the respondents perceived that older women from a BME background were seldom offered the opportunity and the support to express their care or support requirements, that this sub-group of the population would think their physical needs were most often taken into account, whereas their cultural needs were least often taken into account, and that they were seldom (25%) or never (2.8%) involved in decision-making about their own care. Moreover, 44.1% of respondents perceived that older women from a BME background could seldom or never choose which language they wished to use to communicate, and 31.9% believed that this population group was seldom or never provided with information relevant to their ethnic or cultural background.

The study revealed that effective communication has been seen of central importance in maintaining and promoting dignity (Webster & Bryan 2009). As highlighted in the literature and the media, language is a widely recognised barrier for people of minority ethnic backgrounds to accessing health and social care services (Ahmed et al. 2005, Ansari et al. 2009, Wright 2010). Issues around interpretation have also been frequently documented, such as those related to availability of interpreters, difficulties encountered in translating medical terms, and ethical aspects surrounding the use of interpreters in

care settings (Rozario 2005, Mastrocola & Nwabineli 2009). From this survey it is evident that issues around communication and of language remain a pressing concern, especially to those who provided hands on care.

Third, it was evident that gaps identified in the research literature regarding service provision were reflected in the survey (Gerrish 2001, Patel 2003, Bowes et al. 2008, 2011). As already noted, this included relevant support not being provided, information not provided in clients' own language, and inadequate provision of language support services. Based on this survey, the top five barriers which made it difficult to provide intercultural care with dignity were a lack of staff who can speak community language, a lack of interpretation services or limited access to interpreters, a lack of staff training, limited time and not recognising the culturally specific needs of older people. The top two barriers or challenges to providing responsive services were addressing the way local services were accessed, and not taking into account of older people's culturally specific needs when designing services. With regard to key elements which might help respondents provide better care or support to older women from a BME background it is evident that the knowledge and support offered by external organisations which seem to have greater understanding and moreover, greater levels of professional competencies needed to work in an intercultural context could help in the organisation and delivery of more responsive services. Moreover, the intercultural competencies that practitioners already have could more effectively be shared within organisations.

Lastly, issues around engaging and working within an intercultural context were raised. Respondents reported that there were often few referrals of users from a BME background via social services or self-referrals. Most respondents thought that older people from a BME background and their family members were often unaware of services especially mainstream services available for them. They also thought that a social support network was often not in place to facilitate access to relevant services on older people's behalf. In addition, respondents felt unsure how and where to approach them and acknowledged difficulties in informing older people of newly developed programmes or services. Moreover, among some respondents it was stressed that staff members tended to be constrained from learning about and responding to culturally

appropriate care which often required more time and effort to plan and put into practice. Interestingly, although many service providers based in the public or private sector did not see racism and negative attitudes towards BME people as key challenges to the provision of responsive care or support, those who worked in the third sector did indicate negative attitudes towards people from BME backgrounds and racism as barriers.

What is clear in exploring the views of service providers is the importance of addressing issues of anxiety around how to design, develop and deliver responsive, person-centred care to an increasingly diverse client group and moreover, how to define, develop and chart intercultural competencies of social care providers. This survey revealed that some key building blocks are already in place. These included the respondents' links with external, third sector organisations with expertise in age and ageing and in ethnic diversity and older people. This also included the recognition of 'in-house expertise comprising those who expertise in working meaningful across cultures, and the recognition of the need for further development of responsive services. In terms of seeking to understand and explore issues of professional anxiety within an intercultural care or support context, the work of Gunaratnam (2011) on cultural vulnerability as based on upon recognition of mutual vulnerabilities in caring relationships and engagement with professional narratives is important and timely. More work is also needed to explore how best to not only acknowledge diversity and difference within older populations, but design and delivery responsive services and care accordingly. The survey revealed that much more work is also needed to further explore the views of service providers, and the dominant narratives in which they operate.

6. Conclusion

It is clear that the views of older women on dignity, on care, and on care with dignity remains a largely unexplored area and much more research is needed. We were aware that the respondents' perceptions of gendered aspects of care, and specific understandings of care and support as understood by women from a BME background was not going to be sufficiently explored in this survey. More research is needed to map and explore the intersection of gender, age and minority ethnicity as linked to the care practices of service

providers and their views on how older people perceive of the support and care provided by them. As Maynard et al. (2008) and others have argued there is a need to move away from deficit models of analysis which can work to position older women from BME backgrounds as sources of social and policy problems and moreover, based on the limited (but growing) research evidence on older minority ethnic women, as peripheral to wider more general debates on the older population. Rather there remains a need to investigate issues around the meaning and quality of life, and the circumstances which enhance their ability to pursue satisfying lives.

This study illustrates the complex nature of service providers' perceptions of how older women from a BME background may view services. Exploration of service providers' views provides some important insight for the development of effective social care services for older people, in particular older women from a BME background. A better understanding of the perception of services providers along with that of older people themselves can inform future work on dignity in care for older people. Awareness of what constitutes high quality of care with dignity across a range of diverse older population groups, of the impact of societal attitudes to older people and relevant training supported by policies and sufficient resources will result in better care and support for all older people, not least older women from a BME background.

What is also evident is that the concept of dignity and of the provision of dignified care remains largely perceived in acts, actions and behaviours. There remains a need to explore the structural elements which shape how older people are perceived and how they may perceive themselves. It is the social dimensions of dignity that have yet to enter and gain hold in the prevalent dignity narratives and as such, shape how service providers approach and seek to work in an intercultural context.

Implications for policy and practice

- *Dignity has a structural dimension, as well as an interpersonal dimension, both of which are constructed by the act of recognition. It is important to understand the impact that race inequality may have on the lives and wellbeing of older women from minority ethnic backgrounds. This structural dimension must underpin the dignity agenda and the person-centre care agenda.*

- *Learning from the views and perceptions of service providers remains key to the development of responsive services that can provide care to UK's increasingly diverse older population.*

- *Addressing any anxieties and gaps in knowledge and understanding needed by service providers in order to operate successfully in an intercultural context is a pressing concern. Training in intercultural competence should be up-to-date, ongoing, and available to all staff members.*

- *For BME older women, high quality care which takes into account their socio-cultural background, psychological needs, religious beliefs, and life history into consideration can support dignity and respect.*

- *Managers, commissioners and supervisors are tasked with ensuring that strategies are in place to address barriers to accessing services. Outreach work in ethnic minority communities would be helpful in increasing awareness of services and resources available to older people and how they can be approached.*

- *Staff should be given the time to reflect on the impact of their own actions on the people they care or support and moreover evidence their care encounters and experiences.*

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